ATTACHMENT 2
UB-92 (CMS 1450) claim form instructions for nursing home services

(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, ***not*** the form locator descriptions printed on the claim form to avoid denied claims or inaccurate claim payment. Complete all required form locators as appropriate. Do not include attachments unless instructed to do so.

These instructions are for the completion of the UB-92 claim for Wisconsin Medicaid. For complete billing instructions, refer to the National UB-92 Uniform Billing Manual prepared by the National Unified Billing Committee (NUBC). The National UB-92 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-92 Uniform Billing Manual by writing or calling:

American Hospital Association
National Uniform Billing Committee
29th Fl
1 N Franklin
Chicago IL 60606
(312) 422-3390

For more information, go to the NUBC web site at *www.nubc.org/*.

Wisconsin Medicaid recipients receive a Medicaid identification card when initially determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for more information about the EVS.

Form Locator 1 — Provider Name, Address, and Telephone Number

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state and ZIP code. The name in Form Locator 1 should correspond with the provider number in Form Locator 51.

Form Locator 2 — ERO Assigned Number (not required)

Form Locator 3 — Patient Control No. (optional)

Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status (R/S) Report and/or the 835 Health Care Claim Payment/Advice transaction.

Form Locator 4 — Type of Bill

Enter the three-digit type of bill number. Bill numbers for nursing homes include the following:

211 = Inpatient Nursing Home — Admit through Discharge Claim
212 = Inpatient Nursing Home — Interim, first claim

213 = Inpatient Nursing Home — Interim, continuing claim
214 = Inpatient Nursing Home — Interim, last claim

Form Locator 5 — Fed. Tax No. (not required)

Form Locator 6 — Statement Covers Period (From - Through)

Enter both dates in MM/DD/YY format (e.g., November 1, 2003, would be 11/01/03). Include the date of discharge or death. Do not include Medicare coinsurance days.

Form Locator 7 — Cov D.

Enter the total number of days covered by the primary payer, as qualified by the payer organization. Do *not* include the day of discharge or death. Do not include Medicare coinsurance days.

Form Locator 8 — N-C D. (not required)

Form Locator 9 — C-I D. (required for crossover claims)

Enter the number of Medicare coinsurance days.

Form Locator 10 — L-R D. (not required)

Form Locator 11 — Unlabeled Field (not required)

Form Locator 12 — Patient Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Form Locator 13 — Patient Address (not required)

Form Locator 14 — Birthdate (not required)

Form Locator 15 — Sex (not required)

Form Locator 16 — MS (not required)

Form Locator 17 — Admission Date

Enter the admission date in the MM/DD/YY format (e.g., November 1, 2003, would be 11/01/03). The date of admission to the nursing home is the first date the recipient enters the facility as an inpatient for the current residency. (Current residency is not interrupted by bedhold days or changes in level of care or payer status.)

Form Locator 18 — Admission Hr (not required)

Form Locator 19 — Admission Type (not required)

Form Locator 20 — Admission Src

For bill type 211 and 212, enter the code indicating the source of this admission.

Code Structure for Source of Admission		
Code	**Title**	**Description**
1	Physician referral	The recipient was admitted to this facility by the recommendation of his or her personal physician.
2	Clinic referral	The recipient was admitted to this facility by the recommendation of this facility's clinic physician.
3	HMO referral	The recipient was admitted to this facility by the recommendation of an HMO physician.
4	Transfer from a hospital	The recipient was admitted to this facility as a hospital transfer from an acute care facility where the recipient was an inpatient.
5	Transfer from a skilled nursing facility	The recipient was admitted to this facility as a transfer from a skilled nursing facility where the recipient was an inpatient.
6	Transfer from another health facility	The recipient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long term care facilities, and skilled nursing facility recipients that are at a nonskilled level of care.
7	Emergency room	The recipient was admitted to this facility by the recommendation of this facility's emergency room physician.
8	Court/law enforcement	The recipient was admitted to this facility by the direction of a court of law or by the request of a law enforcement agency representative.
9	Information not available	The means by which this recipient was admitted to this facility is not known.

Form Locator 21 — D Hr (not required)

Form Locator 22 — Stat

Enter the code indicating patient status as of the "Statement Covers Period" through date from Form Locator 6.

Code Structure for Patient Status	
Code	**Description**
01	Discharged to home or self care (routine discharge).
02	Discharged/transferred to another short-term general hospital for inpatient care.
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification.
04	Discharged/transferred to an intermediate care facility (ICF).
05	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution.
06	Discharged/transferred to home under care of organized home health service organization.
07	Left against medical advice or discontinued care.
08	Discharged/transferred to home under care of a Home IV provider.
20	Expired.
30	Still patient.

Form Locator 23 — Medical Record No. (optional)

Enter the number assigned to the patient's medical/health record by the provider. This number will appear on the R/S Report and/or the 835 Health Care Claim Payment/Advice transaction.

Form Locators 24-30 — Condition Codes (required, if applicable)

Enter the code identifying a condition related to this claim.

Condition Code Structure for Insurance Codes		
Code	**Title**	**Description**
01	Military service related	Medical condition incurred during military service.
02	Condition is employment related	Recipient alleges that medical condition is due to environment/events resulting from employment.
03	Patient covered by insurance not reflected here	Indicates that recipient/recipient's representative has stated that coverage may exist beyond that reflected on this bill.
05	Lien has been filed	Provider has filed legal claim for recovery of funds potentially due to a recipient as a result of legal action initiated by or on behalf of the recipient.
A5	Disability	Developmentally disabled.
X0		Intensive brain injury.

Form Locator 31 — Unlabeled Field (not required)

Form Locators 32-35 a-b — Occurrence Code and Date (required, if applicable)

Code Structure for Occurrence Codes and Dates		
Code	**Title**	**Description**
01	Auto accident	Code indicating the date of an auto accident.
02	No fault insurance involved — including auto accident/other	Code indicating the date of an accident including auto or other where state has applicable no-fault liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/tort liability	Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/employment related	Code indicating the date of an accident allegedly relating to the patient's employment.
05	Other accident	Code indicating the date of an accident not described by the above codes.
06	Crime victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.

Form Locator 36 a-b — Occurrence Span Code (From - Through) (not required)

Form Locator 37 A-C — Internal Control Number/Document Control Number (not required)

Form Locator 38 — Responsible Party Name and Address (not required)

Form Locators 39-41 a-d — Value Code and Amount (not required)

Form Locator 42 — Rev. Cd.
Enter the revenue code which identifies a specific accommodation, ancillary service, or billing calculation. Enter revenue code "0001" on the line with the sum of all the charges. Do not include Medicare coinsurance days.

Form Locator 43 — Description
Enter the first date of service (DOS) billed in MMDDYY format followed by a dash. Then enter the last DOS being billed in MMDDYY format. Do *not* include the date of discharge or death. Do not include Medicare coinsurance insurance days.

Form Locator 44 — HCPCS / Rates (not required)

Form Locator 45 — Serv. Date (not required)

Form Locator 46 — Serv. Units
Enter the number of covered accommodations days or ancillary units of service for each line item. Do not count or include the day of discharge/death for accommodation codes. Do not include Medicare coinsurance days. The sum of the accommodation days must equal the billing period in Form Locator 43 and must equal the total days in Form Locator 7. For transportation services, enter the number of miles.

Form Locator 47 — Total Charges (by accommodation / ancillary code category)
Enter the usual and customary charges pertaining to the related revenue code for the current billing period as entered in Form Locator 6, "statement covers period." Enter revenue code "0001" to report the sum of all charges in Form Locator 47.

Form Locator 48 — Non-covered Charges (not required)

Form Locator 49 — Unlabeled Field (not required)

Form Locator 50 A-C — Payer
Enter all health insurance payers here. For example, enter "T19" for Wisconsin Medicaid and/or the name of commercial health insurance. Enter "patient liability amount" to identify any patient liability.

Form Locator 51 A-C — Provider No.
Enter the number assigned to the provider by the payer indicated in Item 50 A-C. For Wisconsin Medicaid, enter the eight-digit provider number. The provider number in Form Locator 51 should correspond with the name in Form Locator 1.

Form Locator 52 A-C — Rel Info (not required)

Form Locator 53 A-C — Asg Ben (not required)

Form Locator 54 A-C & P — Prior Payments (required, if applicable)
Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, "OI-P" must be indicated in Form Locator 84.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Form Locator 55 A-C & P — Est Amount Due
Enter the dollar amount of any patient liability.

Form Locator 56 — Unlabeled Field (not required)

Form Locator 57 — Unlabeled Field (not required)

Form Locator 58 A-C — Insured's Name (not required)

Form Locator 59 A-C — P. Rel (not required)

Form Locator 60 A-C — Cert. - SSN - HIC. - ID No.
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or EVS to obtain the correct identification number.

Form Locator 61 A-C — Group Name (not required)

Form Locator 62 A-C — Insurance Group No. (not required)

Form Locator 63 A-C — Treatment Authorization Codes (required, if applicable)
Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF) for all services requiring PA (e.g., ventilator, Acquired Immune Deficiency Syndrome, head injury). Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim. Do not attach the PA to the claim.

Form Locator 64 A-C — ESC (not required)

Form Locator 65 A-C — Employer Name (not required)

Form Locator 66 A-C — Employer Location (not required)

Form Locator 67 — Prin. Diag Cd.
Enter the full *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) (up to five digits) code describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include "E" codes.

Form Locators 68-75 — Other Diag. Codes
Enter the ICD-9-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay. Diagnoses which relate to an earlier episode and which have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim.

Form Locator 76 — Adm. Diag. Cd.
Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

Form Locator 77 — E-Code (not required)

Form Locator 78 — Race/Ethnicity (not required)

Form Locator 79 — P.C. (not required)

Form Locator 80 — Principal Procedure Code and Date (not required)

Form Locator 81 — Other Procedure Code and Date (not required)

Form Locator 82 a-b — Attending Phys. ID

Enter the Unique Physician Identification Number or license number and name.

Form Locator 83 a-b — Other Phys. ID (not required)

Form Locator 84 a-d — Remarks (enter information when applicable)

Commercial health insurance billing information

Commercial health insurance coverage must be billed prior to submitting Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

If the EVS indicates that the recipient has dental ("DEN") or has no commercial health insurance, leave Form Locator 84 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, **and** the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes **must** be indicated in the **first** line of Form Locator 84. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Form Locator 54 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill Wisconsin Medicaid for services that are included in the capitation payment.

Medicare information

Use Form Locator 84 for Medicare information. Submit claims to Medicare before billing Wisconsin Medicaid.

Do not indicate a Medicare disclaimer code when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does not have any Medicare coverage, including Medicare Cost ("MMC") or

Medicare + Choice ("MPC"), for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.

- Wisconsin Medicaid indicates the provider is not Medicare certified.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits or Medicare Remittance Advice, but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate:

Code	Description
M-5	**Provider is not Medicare certified.** This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for DOS before or after their Medicare certification effective dates. Use M-5 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

Form Locator 85 — Provider Representative

The provider or the authorized representative must sign in Form Locator 85. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

Form Locator 86 — Date

Enter the date on which the claim is submitted to the payer.